MILLIMAN WHITE PAPER

Final Rule CMS-2439-F: Medicaid medical loss ratio standards

Essential insights for state Medicaid agencies

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Finalized reporting standards impacting the Medicaid medical loss ratios reported by states and their managed care plans will require state agency action

Executive summary

The Centers for Medicare and Medicaid Services (CMS) has finalized updates to the Medicaid medical loss ratio (MLR) reporting standards as delineated in §438.8(e)(2)(iii)(C) and §438.8(f)(2)(vii) of the 2024 Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality Final Rule published on May 10, 2024. Major regulatory changes in the Final Rule include:

- Mandatory inclusion of state-directed payments (SDPs) in the MLR calculation.
- Increased transparency requirements for provider incentive payments included in the MLR calculation.
- Required managed care plan (MCP) reporting of provider overpayments to the state Medicaid agency within 30 days of identification or recovery.
- Prohibition of indirect expenses from being counted as a quality improvement expense in the MLR numerator.
- More rigorous MCP reporting of expense allocation methodologies.

These changes are set to alter the landscape of state Medicaid agency monitoring procedures and MCP financial reporting, particularly concerning the mandatory inclusion of SDPs and provider incentive documentation requirements for the MLR calculations. Overall, state agencies will need to consider establishing or enhancing their current mechanisms for monitoring MCP compliance with the updated MLR standards, including upgrading their data collection and reporting systems to capture accurate information required under the new MLR standards.

Below are the motivations CMS stated when making the decision to modify the MLR reporting standards:[1]

- Increasing complexity and variability in SDPs resulting in an increased risk of financial mismanagement.
- Promoting increased transparency of SDP payment mechanisms.
- Strengthening oversight and reporting of SDPs and other elements of the MLR calculation.
- Enhancing CMS understanding of provider-based incentive payments.

This white paper delves deeper into specific aspects of the updated MLR reporting standards, including an overview of the major regulatory changes and compliance timelines, with a table summarizing effective dates located in the appendix.

1. The full text of the Final Rule is available at https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08085.pdf. See pages 41026, 41042, 41044, 41056, and 41261.

Inclusion of state-directed payments in MLR calculations

OVERVIEW

Under CFR 438.8, state Medicaid programs must contractually require MCPs to submit an MLR report for each MLR reporting year.[2] Because CMS regulatory guidance had not specifically addressed the inclusion of SDPs in the MLR calculation, some states historically excluded SDPs that were considered ”separate payment terms” from the MLR calculation.[3] These separate payment term SDPs were included in the actuarial rate certification but were a separate add-on to the managed care capitation rates. These payments often were not associated with insurance risk to the MCPs because the revenue payments made to the MCP for the SDP were equal to the distributed provider payments.

Nationally, Medicaid expenditures associated with SDPs (separate payment terms or not) accounted for approximately 20% of overall Medicaid expenditure growth from 2016 to 2023 and totaled $78 billion in federal fiscal year 2023 (or 15.6% of managed care spending), with further growth expected.[4] Additionally, approximately 55% of SDPs that began in calendar year 2021 used separate payment terms.[5]

The Government Accountability Office (GAO) and the Medicaid and CHIP Payment and Access Commission (MACPAC) have both highlighted the elevated risks to Medicaid program integrity and fiscal guardrails associated with the increased use of SDPs.[6] These risks stem from the complexity and variability of SDP arrangements, which can complicate oversight and increase the potential for financial mismanagement.

Under the prior regulatory framework, CMS stated it had significant challenges in understanding the specifics of payments made under SDP arrangements. This includes difficulties in:[7]

- Determining the precise nature, volume, and transaction values of payments made.
- Assessing how actual expenditures align with estimated amounts approved in advance.
- Evaluating the risk of federal funds being used for impermissible or inappropriate payments.

In its January 2021 State Medicaid Director Letter and repeated in the Final Rule, CMS stated SDPs with separate payment terms are “contrary to the nature of risk-based managed care”[8] and the Final Rule disallows SDPs with separate payment terms beginning for contract periods that start on or after July 9, 2027.[9]

> §438.6(c)(6) – state-directed payments are required to be included in actuarially sound capitation rates (i.e., prohibiting use of separate payment terms)

While the future prohibition of SDPs with separate payment terms will result in all SDPs being included in the MLR calculation (as insurance risk would be associated with SDPs included in the managed care capitation rates), the Final Rule now explicitly requires that the MLR calculations must include *all* SDPs in the numerator and denominator while the separate payment terms are being phased out. In its reasoning, CMS states SDP MLR reporting will support CMS oversight activities and references an awareness of existing SDPs that permit MCPs to retain a portion of the SDP funding for administrative costs incurred when processing the SDP’s provider payments.[10]

> §438.8(e)(2)(iii)(C) and (f)(2)(vii) – state-directed payments must be included in the MLR numerator and denominator.

2. For additional background on the Medicaid MLR requirements, please see: https://us.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/2016/medical-loss-ratio-in-mega-reg.ashx.
3. Full text of the Final Rule, at https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08085.pdf, page 41117.
4. Ibid., page 41258.
5. Ibid., page 41105.
6. Ibid., page 41042.
7. Ibid., page 41116.
8. Ibid., page 41105.
9. Ibid., page 41003.
10. Ibid., page 41116.

EFFECTIVE DATE FOR SDP MLR REPORTING

The requirements to include SDPs in the MLR calculation became effective on July 9, 2024 (three years prior to the prohibition of SDPs as separate payment terms). Due to this effective date, there is some room for interpretation on which contract years will be required to comply:

- As of July 9, 2024, MLR reports for some completed contract periods have not yet been submitted to CMS while other contract periods are still in progress.
- Although CMS has been silent on the timing, a reasonable interpretation of this effective date may be to assume MLR submissions *reported* to CMS after July 9, 2024 (rather than contract periods beginning after this date), would be subject to the new standards, even if the MLR submission reflects a prior contract period.
- CMS explicitly stated it had considered the alternative compliance date of no later than the *rating period* for managed care contracts beginning on or after 60 days after the effective date of the Final Rule. Although that delayed compliance date was considered, CMS finalized the effective date with the more immediate date regardless of rating period.[11]
- If this interpretation is correct, then states should be ready to include all SDPs in any CMS MLR submissions reported after July 9, 2024.

IMPACT TO MLR PERCENTAGES

All else equal, the inclusion of separate payment term SDPs in the numerator and denominator of the MLR calculation will increase the calculated MLR. For example, assume an MCP received $100 million in premium revenue, had $85 million in claims expenses, and administered a separate payment term SDP of $20 million. Using a simplified version of the MLR formula, excluding the separate payment term SDP from the numerator and denominator would result in an MLR of 85.0% ($85 million ÷ $100 million). However, including the separate payment term SDP of $20 million in both the numerator and denominator increases the MLR to 87.5% ($105 million ÷ $120 million), increasing the MLR by 2.5 percentage points.

In a second scenario, assume the MCP's claims expense excluding the separate payment term was only $80 million, while premium remained at $100 million, resulting in an MLR of 80.0%. To the extent the state required remittances when actual MLRs are less than 85.0% (and member months are fully credible), this would result in the MCP owing a remittance payment of $5 million. However, if the separate payment term SDP amount of $20 million is added to the numerator and denominator of the calculation, the MLR increases to 83.3% ($100 million ÷ $120 million) and the remittance owed by the MCP decreases to only $2 million ([$100 million + $2 million] ÷ $120 million = 85.0%). In this second scenario, the inclusion of the separate payment term SDP not only increases the MLR from 80.0% to 83.3%, but it also reduces the MLR remittance owed by the MCP from $5 million to $2 million. The table in Figure 1 summarizes the MLR calculations for the first and second scenarios.

FIGURE 1: MLR CALCULATIONS (DOLLARS SHOWN IN MILLIONS)

		SCENARIO 1		SCENARIO 2	
LINE ITEM	**DESCRIPTION**	**EXCLUDING SDP**	**INCLUDING SDP**	**EXCLUDING SDP**	**INCLUDING SDP**
(1)	Premium Revenue	$100	$100	$100	$100
(2)	SDP Revenue	EXCLUDED	$20	EXCLUDED	$20
(3) = (1) + (2)	Total Revenue	$100	$120	$100	$120
(4)	Base Claims Expense	$85	$85	$80	$80
(5)	SDP Expense	EXCLUDED	$20	EXCLUDED	$20
(6) = (4) + (5)	Total Claims Expense	$85	$105	$80	$100
(7) = (6) ÷ (3)	MLR	85.0%	87.5%	80.0%	83.3%
(8)	Remittance Owed	$0	$0	$5	$2

11. Ibid., page 41117.

STATES SHOULD CONSIDER THE FOLLOWING ACTIONS WHEN EVALUATING CMS CHANGES TO MLR STANDARDS AS IT RELATES TO SDPS

As shown in the above examples, the inclusion of separate payment term SDPs in the MLR calculation will increase the MLR percentage and may reduce MCP remittances to the extent a state Medicaid agency requires remittances based on the CMS MLR formula. MLR coverage year reports submitted to CMS must include SDPs in the MLR calculation, but states continue to have flexibility in determining the MLR remittance formula. However, because MLR remittances are considered a risk mitigation strategy,[12] MCP contracts and capitation rates may not be retroactively implemented.

If a state had previously tied the MCP remittance of capitation dollars to the CMS defined MLR formula, it may consider whether to modify its remittance approach to exclude the separate payment term SDPs from the MLR remittance calculation. **To the extent a change in the remittance formula is made, MCP contract language must be clarified or updated before the next contract year begins.** There are several factors that may be evaluated in assessing the impact of separate payment term SDPs on the state's MLR standards:

- Among contracted MCPs in a state, separate payment term SDPs as a percentage of premium revenue and incurred claims may vary, resulting in one MCP more likely reaching the minimum MLR percentage than another.
  - For example, if a separate SDP was specific to a region of the state, MCP market share in that region relative to the rest of the state could result in contracted MCPs having varied MLRs, even if the ratio of other claims and revenue items were equal.
  - State Medicaid agencies should assess how the financial value of separate SDPs assigned to each MCP varies in proportion to the MCP's residual premium revenue and claims expense.
- If the fiscal value of separate payment term SDPs changes between contract years, then, all else equal, MCP MLR percentages will be impacted. State Medicaid agencies should consider how annual modifications to these SDPs will impact MCP MLR and margin opportunities.

Increased transparency requirements for provider incentive arrangements and provider overpayments

OVERVIEW

Since the Medicaid MLR requirements were established in the 2016 final rule, all provider incentive payments are required to be included in the numerator of the MLR calculation as an incurred claims expense.[13] Additionally, these payments are included in the base data when developing future capitation rates. As discussed in the Final Rule, MCPs can offer incentive payments to healthcare providers as a strategy to encourage their participation in the MCPs' networks. Historically, there has been no requirement that incentive arrangements must be linked to a provider meeting specific performance metrics or standards.[14]

In the Final Rule, CMS states that it conducted several in-depth reviews of state oversight of managed care MLR reporting. These reviews found several situations where the incentive arrangement may not have been appropriate to include in the MLR numerator, including:

- Medicaid MCPs executed incentive arrangements without a payment provision based on quantitative clinical or quality improvement standards or metrics.
- Incentive arrangements developed retrospectively or were not aligned with the MLR reporting period.
- Provider incentive arrangements paid inconsistently with the provider contract or state acceptance only based on attestation from senior leadership of the MCP.[15]

12. See https://www.govinfo.gov/content/pkg/FR-2020-11-13/pdf/2020-24758.pdf, page 72774.

13. 42 CFR 438.8(e)(2)(iii)(A) (June 29, 2024).

14. Full text of the Final Rule, at https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08085.pdf, page 41125.

15. Ibid.

In the Final Rule, CMS states its concern that such arrangements could be used to "more easily pay network providers solely to expend excessive funds to increase their MLR numerator under the guise of paying incentives."[16] Furthermore, when these payments are included in the development of future capitation rates, CMS believes the actuarial soundness of the capitation rates may be jeopardized, as the expenditures are not for the provision of care or reasonable operating expenses of the MCP.

KEY CHANGES IN REQUIREMENTS FOR PROVIDER INCENTIVE ARRANGEMENTS

To address these CMS concerns and align with other health insurance markets, Medicaid provider incentive arrangements will be required to comply with several new requirements, as outlined below and defined in §438.3(i). Failure to meet these new requirements will disallow the incentive payments from inclusion in the MLR numerator.

- Provider incentive contracts between MCPs and network providers must adhere to the following requirements:
  - The performance period of the contract must align with the MLR reporting period.
  - The provider must be required to meet clearly defined specific quality improvement or performance metrics before receiving payment from the MCP.
  - The contract must include a specific dollar amount and expected date of payment for meeting the required metrics.
  - The contracts must be signed, dated, and executed by all relevant parties prior to the start of the performance period (i.e., defined and linked to an applicable MLR reporting period or periods).[17]
- States must ensure their MCP contracts contain the following provisions related to provider incentive arrangements:[18]
  - Define the necessary supporting documentation that an MCP must maintain for its provider incentive contracts.
  - Attestations cannot serve as documentation for incentive amounts being included in the MLR calculation.
  - MCPs are required to provide incentive payment contracts and supporting documentation upon request and at a frequency defined by the state.
  - Program integrity sections of the contracts must include cross-references to provider incentive arrangement documentation requirements.[19]

CMS believes these key changes to the provider incentive arrangements and documentation provisions will reduce the risk of MCPs using unsound provider incentive payments to inflate their MLR numerators, thereby closing a potential source for MLR remittance manipulation.[20]

KEY CHANGES IN PROVIDER OVERPAYMENTS

In the Final Rule, CMS reiterates the importance of MCPs reporting provider overpayments, as they directly impact the incurred claims component of the MLR calculation and development of actuarially sound capitation rates.[21] While existing regulations under §438.608(a)(2) require an MCP to provide "prompt" reporting of overpayments identified or recovered, CMS had previously not defined the timeframe for prompt reporting. Under the Final Rule, modifications to regulation §438.608(a)(2) clarify the provision for MCP's state reporting requirements related to the prompt and timely reporting of all overpayments identified or recovered. MCPs will now be required to report provider overpayments to the state within 30 calendar days of identification or recovery. CMS's expectations for the key changes to provider overpayments include:

- Continuing to protect against fraud and other overpayments in the Medicaid program.
- Mitigating the potential for provider overpayments to inappropriately inflate the MLR numerator.
- Improving integrity efforts and ensuring consistency in definitions among states and MCPs.

16. Ibid., page 41126.
17. 42 CFR 438.3(i)(3).
18. Full text of the Final Rule, at https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08085.pdf, page 41126.
19. 42 CFR 438.3(i)(4).
20. Full text of the Final Rule, at https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08085.pdf, page 41125 and 41126.
21. Ibid., pages 41136 and 41262.

EFFECTIVE DATE

The new provider incentive arrangements in §438.3(i) have dual-phased effective dates. The provision requiring that provider incentives must be coupled with clearly defined quality measures is effective on July 9, 2024.[22] However, the requirements to include updated provider incentive language in MCP contracts and the provider overpayment provisions in §438.608(a)(2) will be effective as of the first rating period beginning on or after July 9, 2025.

STATES SHOULD CONSIDER THE FOLLOWING ACTIONS WHEN EVALUATING CMS CHANGES TO MLR STANDARDS

- Create an inventory of all provider incentive arrangement contracts executed by the MCPs, collecting information consistent with the requirements under §438.3(i), and assess the degree of current noncompliance with new regulations among the MCPs.
  - Exclude provider incentives that do not meet the new regulatory requirements from any MLR report submitted to CMS after July 9, 2024.
- Work proactively with contracted MCPs to develop the necessary documentation standards for provider incentive arrangement, including:
  - Clearly specifying the exact documentation required to substantiate provider incentive arrangements.
  - Define the deadlines and frequency for the submission of supporting documentation, i.e., upon request and with any frequency the state deems necessary.
- Update or establish a provider overpayment reporting mechanism to allow MCPs to promptly report provider overpayments to the state.

Prohibited costs in quality improvement activities

OVERVIEW

The prior Medicaid MLR regulations did not explicitly prohibit MCPs from including indirect costs or overhead for quality improvement activity (QIA) expenditures. CMS believes this lack of prohibition has led to the inclusion of such costs in the MLR numerator, potentially inflating MLR calculations and creating a discrepancy between standards in the private market and those in Medicaid and CHIP.[23] In the Final Rule, CMS provides a cross-reference to the private market rule governed by regulation 45 CFR 158.150,[24] with the overarching concept that administrative and cost containment expenses not directly related to QIA must be excluded from the MLR calculation.

KEY CHANGES IN REQUIREMENTS FOR PROHIBITED QIA EXPENDITURES

Allowable costs in the MLR numerator must be clearly connected to healthcare quality improvement activities and should include costs that do not inflate, but rather are incurred to further quality improvement. Salary costs and non-salary benefits of employees performing quality improvement activities continue to be allowable if the costs are clearly documented for improving healthcare quality, meeting the definition §438.8(e)(3).[25] When the costs provide no direct or quantifiable benefit to enrollee health, these costs are prohibited.[26,27] Therefore, the portion of employee time spent on non-QIAs cannot be considered quantifiable QIA expenses. MCPs will need to have supporting documentation and retain records documenting the breakout of salary and benefit costs where this applies.[28] Examples of indirect costs that should not be classified as QIA cited by CMS include office expenses, human resources, counsel/executive salaries, computer/telephone usage, travel and entertainment, parties and retreats, IT systems, or marketing products.[29,30]

22. Ibid., page 41130.
23. Ibid.
24. See https://www.ecfr.gov/current/title-45/subtitle-A/subchapter-B/part-158/subpart-A/section-158.150.
25. Full text of the Final Rule, at https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08085.pdf, pages 41131, 41132, and 41261.
26. Ibid., pages 41131 and 41132.
27. See https://www.govinfo.gov/content/pkg/FR-2022-05-06/pdf/2022-09438.pdf, page 27351.
28. Full text of the Final Rule, at https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08085.pdf, page 41132.
29. Ibid., page 41131.
30. See https://www.govinfo.gov/content/pkg/FR-2022-05-06/pdf/2022-09438.pdf, page 27351.

In response to several industry comments, CMS provides the following additional overarching guidance to states:[31]

- States need to act as the gatekeepers for the MLR reporting, as outlined in regulation 438.66, by developing oversight processes and tools to ensure that inappropriate overhead and indirect expenses are not included.
- States should be aware that, if an MCP cannot separately identify indirect or overhead expenses from QIA cost, then the state should disallow the entire QIA expenditure in the MLR calculation. In response to several commenters, CMS plans to examine state MLR oversight practices related to ensuring utilization management expenses, which are explicitly excluded from being classified as a QIA under 45 CFR 158.150, are not reported as a QIA in MLR reporting.

EFFECTIVE DATE

States and MCPs must comply with 438.8(e)(3) by July 9, 2024.

STATES SHOULD CONSIDER THE FOLLOWING ACTIONS WHEN EVALUATING CMS CHANGES TO MLR STANDARDS:

- Improved oversight to monitor MCPs, consistent with requirements under §438.66:
  - Review the state's current oversight practices specifically related to QIA reported by MCPs and implement procedures to ensure QIA reported in the MLR calculations are following the new requirements. This could include incorporating compliance audits of MCP-submitted MLR data.
  - Review the state's current Medicaid MLR reporting instructions and update them, if necessary, to clarify requirements for managed care plans regarding expense allocation as described in regulations §438.8(g) and §438.8(k)(1)(vii).
- Establish or enhance the state's mechanisms for monitoring MCP compliance with the updated MLR standards. This could involve regular reporting, audits, and analyses to ensure that MCPs are accurately reporting MLR data and meeting the required standards.
- Evaluate and, if necessary, upgrade the state's data collection and reporting systems to ensure they can accurately capture and report the information required under the new MLR standards. Ensure that data privacy and security are maintained.

Expanded QIA allocation methodology

OVERVIEW

MCPs are currently required to document their allocation methodologies submitted with their MLR calculation as part of the MLR standards in § 438.8(k)(1)(vii). For MCPs that operate across multiple states or lines of business (e.g., Medicaid, commercial, Medicare Advantage), the allocation methodology determines how an MCP's expenses are classified under a specific state or product. However, as CMS cited in the Final Rule, there are recent examples where MCPs are inadequately documenting their allocation methodologies and/or including unrelated expenses from non-Medicaid lines of business in the Medicaid MLR calculation under the prior standards.[32] This may result in the Medicaid MLR being misrepresented or inflated and could potentially decrease an MCP's MLR remittance payment.

KEY CHANGES IN REQUIREMENTS FOR ALLOCATION METHODOLOGY

As a result of CMS's desire for clarity on the expense allocation methods reported by MCPs in Medicaid MLR reporting, the Final Rule dictates significantly more detailed descriptions of expense allocation within the MLR reports that MCPs must submit to state Medicaid agencies. MCPs will be required to provide detailed descriptions of methods used to allocate expenses, including incurred claims, quality improvement expenses, federal and state taxes and licensing or regulatory fees, and other non-claims costs as described in the private market rule §158.170(b). CMS declined to provide specific expense allocation recommendations and instead deferred to the states for oversight and guidance for financial reporting.

31. Full text of the Final Rule, at https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08085.pdf, page 41131.

32. CMS (March 2023). Oregon Medicaid Managed Care Medical Loss Ratio Audit. Retrieved July 31, 2024, from https://www.cms.gov/files/document/oregon-medicaid-managed-care-medical-loss-ratio-report.pdf.

EFFECTIVE DATE

States and MCPs must comply with these requirements by July 9, 2024.[33]

STATES SHOULD CONSIDER THE FOLLOWING ACTIONS WHEN EVALUATING CMS CHANGES TO MLR STANDARDS:

Similar to actions for prohibited QIA costs, states should consider similar actions as noted above to improve oversight of MCP MLR reporting that include:

- Develop standard templates for MCPs to describe their expense allocation processes and provide detailed guidance on how to complete the templates.
- Work with MCPs to develop a standard cost allocation methodology for QIA that is focused on meeting regulatory requirements. This cost allocation methodology could identify specific cost drivers for each type of expense that would allow for standardized allocation methodologies.
- If an MCP's QIA expenses are allocated from corporate departments that provide services to multiple insurance markets and/or multiple Medicaid states, then states should review contracts between the local health plan and the corporate department to ensure the contract addresses how allocations will be assigned to the local plan and how often these procedures will be reviewed or adjusted.

Key implementation considerations for state Medicaid agencies

The MLR reporting changes mandated by the Final Rule will require immediate action from state Medicaid agencies to ensure compliance. State Medicaid agencies should consider the following key actions:

- State Medicaid agencies will need to conduct detailed reviews of the new MLR standards and their existing contracts and guidelines to identify necessary updates or improvements.
- It is essential for all relevant personnel and stakeholders to fully comprehend the MLR reporting changes; implementing a strong training and communication strategy will be critical in achieving this goal. Communication with both MCPs and providers will be required.
- After revising policies, procedures, and contracts to align with the new MLR standards, state Medicaid agencies should ensure that MCPs and providers adhere to the updated guidelines by establishing new or improved monitoring and compliance mechanisms to promote adherence to the updated MLR standards.
- Continuous review and adjustment processes should be established to address any limitations or challenges faced as new MLR reporting and documentation requirements are implemented.

Summary

In conclusion, the Final Rule represents a significant shift in Medicaid MLR reporting standards, mandating the inclusion of SDPs, and enhancing transparency requirements for provider incentive payments. These changes aim to mitigate financial mismanagement risks, improve oversight, and align Medicaid reporting with broader health insurance markets. **State Medicaid agencies must promptly adapt to these new regulations by updating their monitoring procedures, data collection systems, and compliance mechanisms to ensure accurate and secure reporting.**

The effective dates for these changes (summarized in the appendix) start as early as July 9, 2024, necessitating immediate action from state agencies to revise contracts, implement training programs, and establish robust oversight frameworks. By proactively addressing these requirements, state Medicaid agencies can not only ensure compliance but can also enhance the integrity and transparency of Medicaid managed care financial reporting. This strategic alignment with CMS's updated standards will ultimately contribute to more effective management of Medicaid funds.

33. Full text of the Final Rule, at https://www.govinfo.gov/content/pkg/FR-2024-05-10/pdf/2024-08085.pdf, page 41134.

Appendix: MLR-Related Effective Dates in the Final Rule

We have listed the Medicaid citations in this appendix in order as the citations appear in the body of this report:

LIST OF EFFECTIVE DATES BY MEDICAID CITATION IN ORDER OF APPEARANCE IN THE PAPER	
Medicaid Citation	§ 438.8(e)(2)(iii)(C)
Separate CHIP Citation (as applicable)	N/A
Description`	MLR: Reporting of SDPs in incurred claims for the MLR numerator
Applicability Date in Final Rule	Effective Date of the Final Rule | July 9, 2024
Medicaid Citation	§ 438.8(f)(2)(vii)
Separate CHIP Citation (as applicable)	N/A
Description	MLR: Reporting of SDPs in premium revenue for the MLR denominator
Applicability Date in Final Rule	Effective Date of the Final Rule | July 9, 2024
Medicaid Citation	438.8(e)(2)(iii)(A)
Separate CHIP Citation (as applicable)	§ 457.1203(c)
Description	MLR: Standards for provider incentives
Applicability Date in Final Rule	Effective Date of the Final Rule | July 9, 2024
Medicaid Citation	§ 438.8(c)(6)
Separate CHIP Citation (as applicable)	N/A
Description	SDP: Payment to MCOs, PIHPs, and PAHPs
Applicability Date in Final Rule	First rating period beginning on or after July 9, 2027
Medicaid Citation	§ 438.608(a)(2)
Separate CHIP Citation (as applicable)	§ 457.1285
Description	Contract requirements for prompt reporting
Applicability Date in Final Rule	First rating period beginning on or after July 9, 2025
Medicaid Citation	§ 438.3(i)(3)-(4)
Separate CHIP Citation (as applicable)	§ 457.1201(h)
Description	Contract requirements for provider incentive payments
Applicability Date in Final Rule	First rating period beginning on or after July 9, 2025
Medicaid Citation	438.608(e)
Separate CHIP Citation (as applicable)	§ 457.1285
Description	Standards for provider incentive or bonus arrangements
Applicability Date in Final Rule	First rating period beginning on or after July 9, 2025
Medicaid Citation	§ 438.8(e)(3)(i)
Separate CHIP Citation (as applicable)	§ 457.1203(c)
Description	MLR: Prohibited costs in quality improvement activities
Applicability Date in Final Rule	Effective Date of the Final Rule | July 9, 2024
Medicaid Citation	§ 438.8(k)(1)(vii)
Separate CHIP Citation (as applicable)	§ 457.1203(f)
Description	MLR: Additional requirements for expense allocation methodology
Applicability Date in Final Rule	Effective Date of the Final Rule | July 9, 2024

Source: https://www.medicaid.gov/medicaid/managed-care/downloads/applicability-date-chart-mc.pdf.

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